

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042910

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **1371**

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF H. F. Mundy, M.D. Medical Certification

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Joseph,		c. CITY OR TOWN St. Joseph,	
Length of stay in 1b 63yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 611 No 11th		d. STREET ADDRESS (If outside, give location) 611 No 11th	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Linza Last Baker		4. DATE OF DEATH Month Nov Day 21 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1900
10a. USUAL OCCUPATION (Give kind of work done during total life, even if retired) Re Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE (last birthday) 63
11a. FATHER'S NAME Zebediah Baker		11b. MOTHER'S MAIDEN NAME Elizabeth Brown	10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0
12. BIRTHPLACE (City and state or country) Buchanan Co, Mo		13. CITIZEN OF WHAT COUNTRY U.S.A.	
14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW#1	
16. SOCIAL SECURITY NO. none		17. INFORMANT Leslie Baker, Faucett Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebral Hemorrhages		INTERVAL BETWEEN ONSET AND DEATH 2mos.	
DUE TO (b) Cardio Vascular Disease		2yrs	
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 9:15P.M. Month, Day, Year Aug. 5, 1961	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Joseph, Mo		
21. I attended the deceased from Aug. 5, 1961 to 11/21/63 and last saw her alive on 11/21/63 Death occurred at 9:15P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED Nov 23-1963	
22a. SIGNATURE H. F. Mundy M.D.		22b. ADDRESS St. Joseph, Mo	
23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION Burial	23b. DATE 11/25/63	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Ft Leavenworth Kansas
24. FUNERAL DIRECTOR John E. Krupp	25. DATE RECD. BY LOCAL REG. Nov 27, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit No. 11-22-63

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

_____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John E. Rupp

Licensed Embalmer No. _____

P. O. Address _____

3986
St. Joseph Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.